Pramlintide (Symlin®) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER	RETAIL
IF the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here ☐	**IF the prescription is to be filled at a retail pharmacy under the TRICARE Retail Pharmacy Program, check here** ☐
• The provider should complete the form, sign, and date • The provider may **fax** the completed form and the prescription to **1-877-895-1900** or 1-602-586-3911 (commercial) **OR** • The patient may attach the completed request form to the prescription and **mail** it to the TMOP at: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**	To request prior authorization, the provider may **call** this number: • **1-866-684-4488** OR • The provider may complete the form, sign, date, and **fax** to **1-866-684-4477**

Prior authorization criteria and a copy of this form are available at: http://www.tricare.osd.mil/pharmacy/prior_auth.cfm. This prior authorization has no expiration date.

Drug for which Prior Authorization is requested: **Pramlintide (Symlin®)**

Step 1

Please complete patient and physician information (Please Print)

Patient Name: _____
Address: _____
_____
Sponsor ID # _____

Physician Name: _____
Address: _____
_____
Phone #: _____
Secure Fax #: _____

Step 2

Please complete the clinical assessment:

1. Is this a continuation of therapy with pramlintide?	☐ Yes Coverage approved	☐ No Proceed to Question 2
2. Has the patient experienced recurrent severe hypoglycemia requiring assistance within the last 6 months OR is the patient typically unaware of the occurrence of hypoglycemia?	☐ Yes Coverage not approved	☐ No Proceed to Question 3
3. Does the patient have a confirmed diagnosis of gastroparesis or does he/she require the use of drugs to stimulate gastrointestinal motility?	☐ Yes Coverage not approved	☐ No Proceed to Question 4
4. Does the patient have a HbA1c ≤ 9%?	☐ Yes Proceed to Question 5	☐ No Coverage not approved
5. Is the patient currently on mealtime insulin?	☐ Yes Proceed to Question 6	☐ No Coverage not approved
6. Is the patient adherent to their current insulin regimen?	☐ Yes Proceed to Question 7	☐ No Coverage not approved
7. Does the patient regularly and reliably monitor blood glucose levels 3 or more times per day and is the patient capable of monitoring blood glucose levels pre- and post-meals and at bedtime?	☐ Yes Proceed to Question 8	☐ No Coverage not approved
8. Has the patient failed to achieve adequate control of blood glucose levels despite individualized management of insulin therapy?	☐ Yes Proceed to Question 9	☐ No Coverage not approved
9. Is the patient under the guidance of a health care provider skilled in use of insulin and supported by the services of a diabetes educator?	☐ Yes Coverage approved	☐ No Coverage not approved

Step 3

I certify the above is true to the best of my knowledge.
Please sign and date:

_____ _____
Prescriber Signature Date

Latest revision: October 2005